CRSA Subcontractor Delegated Functions CRSA Oversight
CRS – Flagstaff
October 1, 2007

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
Claims/Encounters	6/5-7/07	September 25-27, 2008	CS15 – CRS Flagstaff must provide a project plan for the development and implementation of the capability of receiving and paying at least 25% of all claims electronically (excluding claims processed by PBM).	The FCRS Project Plan for electronic claims is attached. Please note that this plan in Microsoft Project software. (FCRS Project Electronic Claims) **Accepted 10/1/07**
Coordination of Care	6/5-7/07	September 25-27, 2008	MM10 - CRS Flagstaff must ensure coordination of care with all PCP's of AHCCCS members by copying all services to primary physicians. MM10 – CRS Flagstaff must include appointment times, attendance to complete transfer tracking, and incoming total transfer information in the transfer log.	All transcriptions are currently forwarded to all PCPs by our medical records clerk. The bottom of each dictation includes a comment that it was sent to the PCP and the date on which it was sent. This date is manually entered on the on the bottom of the each transcription by our medical records clerk. FCRS has updated its transfer log to include a column to track appointment dates and attendance at the appointment. **9/28/07 Accepted -** MM/UM Program will monitor compliance during quarterly site visits Incoming total transfers had been logged on the new member enrollment log which contains a column to identify if the patient is a transfer or not. (see newest transfer log which was sent to Jennifer Vehonsky on 14 Sept 2007). **9/28/07 Accepted -** MM/UM Program will monitor compliance during

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				quarterly site visits
			NS1 – CRS Flagstaff must meet 45-day timelines for members' referrals to specialty clinic appointments.	Gaps were identified in Genetics, Neurology, Neurosurgery and Ophthalmology. This gap analysis was based upon 43 patients seen in 11 separate clinics which is not a statistically significant volume. Genetics: The FY08 contract was revised to eliminate field clinics. We are in the midst of negotiations with the genetics provider to offer 1 ½ day clinics at Flagstaff every month beginning in Dec 2007 which will offer services every month instead of previous every 60 days plus field. We believe this change will meet the 45 day requirement. Neurology: A backlog was caused by the departure of Dr Tarby. We have added Dr Narayanan and started an additional quarterly Friday and Saturday clinic in May 2007. **Further response due 10/20/2007**
			NS1 – CRS Flagstaff must analyze the availability of specialty providers within in its catchment area and formulate a plan to meet specialty appointment needs of its members, whether by increasing membership in the provider network and agreements for the provision of services by out of network specialists, increasing the number of clinics held on site, and/or seeking specialty services for its members via partial or full transfers to	We are still actively working with St Joes for additional neurology support, however due to the major shortage of pediatric neurologists in Arizona, we anticipate about a 50-60 day lead time for this service. **Further response due 10/20/2007**

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			other CRS sites. NS4 – CRS Flagstaff must develop a written pharmacy policy / process. NS4 – CRS Flagstaff must develop a mechanism to provide urgent pharmacy services to members during non-CRS clinic hours. QM11 – CRS Flagstaff must ensure the consultation report is sent to BOTH the referring physician and health plan/program contractor within 30 days of the first clinic visit and is documented in the medical record. QM11 – CRS Flagstaff must ensure the approval notices to BOTH the referring physician and health/plan program contractor are sent within 10 working days and are documented in the medical record. QM11 – CRS Flagstaff must ensure eligibility denial notifications are sent to BOTH the referring physician and health plan/program contractor within 5 working days of denial determination and are documented in the medical record.	FCRS is working with the FMC pharmacy to create an option for CRS patients to obtain prescriptions from the in house pharmacy at FMC during non-CRS hours. This coordination must also be done with the ER since the patients need a location. Anticipate completion of this coordination by 31 Dec 2007. **9/28/07 Accepted** contingent upon submission of written pharmacy policy. MM/UM Program will monitor the implementation of process during quarterly site visit. FCRS implemented a new process in June 2007 to meet this requirement. Our medical records clerk and compliance clerk ensures the documentation of the initial consultation is sent to the PCP and the AHCCCS plan if applicable. The bottom of each transcription now indicates the date that this was forwarded to the PCP and AHCCCS plan (if applicable). These are currently being sent via mail to the PCP and FAX to the AHCCCS plan with confirmations filed. FCRS is researching the option of the purchase of a FAX machine for the medical records clerk to use for forwarding

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				documentation to the PCP. FCRS has added a new policy titled Case Management Care Coordination which outlines the timeframes for eligibility notifications. (Case Management Care Coordination) **Additional response due 10/20/07**
			GS4B – CRS Flagstaff must provides timely, written notification to the member's primary AHCCCS plan when CRS Flagstaff determines that the service requested is not a CRS covered benefit.	As per the CRSA report, the current policy and letter templates meet current requirements. **Additional response due 10/20/07**
Corporate Compliance	6/5-7/07	September 25-27, 2008	No deficiencies	N/A
Credentialing	6/5-7/07	September 25-27, 2008	QM9 – CRS Flagstaff must demonstrate that the FMC board has approved amendments to the By-Laws and show implementation within the credentialing/re-credentialing files. Flagstaff Medical Center must approve the Bylaw revisions as outlined in the May 2, 2007 Corrective Action Plan and demonstrate implementation of those provisions.	The audit report states that compliance with the CAP will satisfy this standard. FCRS is working with FMC Medical Staff to meet this requirement. **9/21/07 Accepted** contingent on demonstrated compliance.
Eligibility	6/5-7/07	September 25-27, 2008	No deficiencies	N/A
Financial Reporting	6/5-7/07	September 25-27, 2008	FM1 – CRS Flagstaff must submit accurate, complete and timely financial statements consistent with CRS Financial Reporting Guide requirements. FM1 – CRS Flagstaff must have processes in place to insure that reports that feed the financial statement package are updated and accurate.	FCRS has implemented a process of coordinating the completion of the quarterly financial review between the FMC financial office and the CRS office to ensure a through analysis of any variances over 5% with documentation in the quarterly financial report. The last three reports were turned on the day due, one day later or with an

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Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
				approved extension. **Response due 10/5/2007**
Grievance/Complaints System	6/5-7/07	September 25-27, 2008	GS1 – CRS Flagstaff must provide members with written Notices of Action and/or Notices of Extension that meet required format standards.	As per the report, from Jan - Mar 2007, FCRS has correctly submitted case files in the correct format and improved in writing easily understood language. FCRS will continue and will forward any questions related to appropriate language to ADHS for review prior to sending to any patients or plans. Until CRSA states differently FCRS will continue to send all letters and a log to CRSA on a weekly basis. **9/24/07 Accepted**
			GS2 – CRS Flagstaff must provide members with written Notices of Action that meet required content standards.	As per the report, the current policy and letter templates meet current requirements. **9/24/07 Accepted** with ongoing monitoring
			GS3 – CRS Flagstaff must provide members with written Notices of Action within the required timeframes.	As per the audit report, FCRS has significantly improved it's compliance over the past few months. The new CRSA service denial log now reflects the date of request, timeliness can now be determined. **Further response due 10/20/07.**
			GS4 – CRS Flagstaff must provide the member with a written Notice of Extension when taking more than 14 (standard) or 3 (expedited) working days to decide initial request for service authorization, or when the CRS	As per the CRSA report, the current policy and letter templates meet current requirements **Further response due 10/20/07.**

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			Flagstaff determines that the service requested is not a CRS covered benefit, and refers the request to the member's primary AHCCCS plan. GS4A – CRS Flagstaff must provide members with written Notices of Extension that meet required content standards.	As per the CRSA report, the current policy and letter templates meet current requirements. **9/24/07 Accepted**
Medical Management – Concurrent Review	6/5-7/07	September 25-27, 2008	MM3 – CRS Flagstaff must: revise the Prior Authorization, Concurrent, and Retrospective review processes to specify that the all staff who are involved in medical necessity determination, including the Medical Director, shall participate in inter-rater reliability training & testing. MM3 – CRS Flagstaff must indicate on the Concurrent and Retrospective Review processes that the medical review professional staff (RN, BSN Nurse Practitioner) has appropriate training to apply CRS medical criteria or make medical decisions. MM3 – CRS Flagstaff must update the Concurrent and Retrospective Review forms to indicate the Place of Service. MM3 – CRS Flagstaff must amend the concurrent review process to clearly state that all prior authorized stays will have a specific date by which the need for continued stay will be reviewed. MM3 – CRS Flagstaff must develop a process and document meeting timelines for concurrent review and the action taken when timelines are not met.	FCRS UM staff to include Dr Austin and Pam Garcia participated in the initial CRSA inter-rater reliability process sent to sites 6/28/2007 and did participate in the process sent 8/30/2007. Also both (sic) Dr Austin, Pam Garcia, Donna Kapellan and Sheila Schill attended InterQual training held 6 Aug 2007. FCRS updated it's policies for Concurrent and Retrospective Review on 6 Sept 2007 to indicate that all RNs performing UM apply CRS medical criteria or make medical decisions within the scope of their license. FCRS has updated the concurrent and retrospective review policies to indicate the Place of Service and that a specific date for re-review has been identified. The addition of a timeline to review concurrent stays will improve the process of verifying timelines have been met for concurrent review. FCRS will improve it's documentation on retrospective

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
			MM3 – CRS Flagstaff must revise the concurrent review process to indicate that all prior authorized stays will have a specific date by which the need for continued stay will be reviewed. MM9 – CRS Flagstaff must ensure that concurrent reviews meet required timelines with documented new review dates. A corrective action plan for missed timelines must be established.	reviews to more clearly identify why any service has been denied. (Concurrent Review, Retrospective Review) **Accepted 9/28/2007** CRSA reviewed one record for one out of state patient. In the nine day period they were hospitalized, FCRS did follow up on care but Stanford did not return the phone call. During next FY, all out of state patients will be managed by Phoenix who will be responsible for concurrent review. There was no feedback in this report related to concurrent reviews of FCRS patients; therefore FCRS is unsure what must be improved in relation to concurrent review timelines for these patients. **Accepted** contingent on receipt of revised concurrent review policy that amends paragraph B1 to state that "authorization for institutional stays will be reviewed within three **calendar** days of admission. The next review date, **which will be no later than 72 hours from the previous review,** will be identified on the concurrent review form and documented."
Medical Management – Prior Authorization	6/5-7/07	September 25-27, 2008	MM3 – CRS Flagstaff must: revise the Prior Authorization, Concurrent, and Retrospective review processes to	FCRS UM staff to include Dr Austin and Pam Garcia participated in the

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
			specify that the all staff who are involved in medical necessity determination, including the Medical Director, shall participate in inter-rater reliability training & testing.	initial CRSA inter-rater reliability process sent to sites 6/28/2007 and did participate in the process sent 8/30/2007. Also both Dr Austin, Pam Garcia, Donna Kapellan and Sheila Schill attended InterQual training held 6 Aug 2007. FCRS updated its policies for Concurrent and Retrospective Review on 6 Sept 2007 to indicate that all RNs performing UM apply CRS medical criteria or make medical decisions within the scope of their license. FCRS has updated the concurrent and retrospective review policies to indicate the Place of Service and that a specific date for re-review has been identified. The addition of a timeline to review concurrent stays will improve the process of verifying timelines have been met for concurrent review. FCRS will improve it's documentation on retrospective reviews to more clearly identify why any service has been denied. (Concurrent Review, Retrospective Review) **Accepted 9/28/2007**
			MM5 – CRS Flagstaff must revise their Prior Authorization process to include non-formulary medications on their list of services to be prior-authorized.	FCRS has revised its prior authorization process to include non-formulary medications to be in compliance with the 7/1/2007 version of the RCCPM. FCRS will improve it's documentations for PSR denials and

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
				does forward PSR denials to the Compliance clerk who ensures that a notice to the provider, AHCCCS, and the family are sent. (Prior Authorizations) **Accepted 9/28/07.** CRSA will monitor the implementation of the process through quarterly site visits.
Medical Management – Retro Review	6/5-7/07	September 25-27, 2008	MM3 – CRS Flagstaff must: revise the Prior Authorization, Concurrent, and Retrospective review processes to specify that the all staff who are involved in medical necessity determination, including the Medical Director, shall participate in inter-rater reliability training & testing. MM3 – CRS Flagstaff must indicate on the Concurrent and Retrospective Review processes that the medical review professional staff (RN, BSN Nurse Practitioner) has appropriate training to apply CRS medical criteria or make medical decisions. MM3 – CRS Flagstaff must update the Concurrent and Retrospective Review forms to indicate the Place of Service.	FCRS UM staff to include Dr Austin and Pam Garcia participated in the initial CRSA inter-rater reliability process sent to sites 6/28/2007 and did participate in the process sent 8/30/2007. Also both Dr Austin, Pam Garcia, Donna Kapellan and Sheila Schill attended InterQual training held 6 Aug 2007. FCRS updated its policies for Concurrent and Retrospective Review on 6 Sept 2007 to indicate that all RNs performing UM apply CRS medical criteria or make medical decisions within the scope of their license. FCRS has updated the concurrent and retrospective review policies to indicate the Place of Service and that a specific date for re-review has been identified. The addition of a timeline to review concurrent stays will improve the process of verifying timelines have been met for concurrent review. FCRS will improve it's documentation on retrospective

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
				reviews to more clearly identify why any service has been denied. (Concurrent Review, Retrospective Review) **Accepted 9/28/2007**
			MM9A – CRS Flagstaff must revise their Retrospective Review form to include all required elements for retrospective review.	FCRS has updated the retrospective review policies to indicate the Place of Service and that a specific date for re-review has been identified. **Accepted 9/28/07.** CRSA will monitor the implementation of the process through quarterly site visits.
			MM9A – CRS Flagstaff must include Medical Director in their Inter-Rater Reliability testing; and indicate that in the Retrospective Review Policy.	The policy was also updated to include the Medical Director in the Inter-Rater Reliability testing. (Retrospective Review) **Accepted 9/28/07.** CRSA will monitor the implementation of the process through quarterly site visits.
Quality of Care Issues	6/5-7/07	September 25-27, 2008	QM4 – CRS Flagstaff must establish a policy/process for monitoring its delegated entities on an ongoing basis and review them formally at least annually. QM4 – CRS Flagstaff must ensure that the subcontractor implements corrective action if any deficiencies are identified. QM4 – CRS Flagstaff must have evaluation reports and CAP documentation, as necessary, to ensure quality for all delegated activities.	FCRS has established a policy titled Contract Monitoring for DME contractors with a checklist to evaluate compliance with their current contracts. (Contract Oversight Monitoring for DME) **9/21/07 Accepted**

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CRS at St. Joseph's Hospital
October 1, 2007

Subcontractor Function	Date of Last Review	Next Date of Review	Identified Deficiencies	Corrective Action Plan Status
Claims/Encounters	5/22-23/07	11/6-8/08	CS 4 - CRS at St. Joseph's must ensure consistent and timely adjudication of claims within contract requirements.	9/5/07 Accepted with ongoing monitoring. CRS will continue to: Monitor claims on a daily basis by date of receipt to ensure timely adjudication, if identified issues with claims aging, claims will be redistributed to staff and productivity will be closely monitored until claims adjudication productivity returns to appropriate turn around time. Continue to monitor claims productivity by claims staff on a monthly basis. Continue to review claims aging report on a monthly basis to identify trends or issues. CRS did not meet the 30-day timely payment guideline once in October 2006. The 60-day guideline was missed by less than a week between September & March. Since March CRS has been compliant with both the 30 day & 60 day requirement.
			CS 14A - CRS at St. Joseph's must be in compliance with contractual requirements for slow payment penalties.	9/07/07 Accepted with ongoing monitoring. System changes were needed to implement the requirement for slow pay penalties. Rehab Manager is currently testing the slow pay programming. It is scheduled to go live in September of 2007. CRS will monitor implementation on at least a quarterly basis to ensure compliance.

Coordination of Care	5/22-23/07	11/6-8/08	MM 10 - CRS at St. Joseph's must improve documentation to members' PCPs to support quality medical management. QM 11 – CRS must ensure consult reports are sent to referring Dr & health plan. CRS must ensure approval notices are sent to referring Dr & health plan w/in 10 days CRS must ensure eligibility denial notifications are sent to both referring Dr & health plan.	9/17/07 Accepted with ongoing monitoring. CRS will continue to invite PCP's to planning clinics when known. Notify PCP and document in record when member is lost to follow-up Continue to auto-fax notes to PCP from transcription Continue to fax enrollment information to PCP Continue to enhance list of PCP fax numbers via regular downloads of WebMD information Continue to have front desk ask member & update system with PCP name. 8/29/07 Not Accepted. Response due 10/15/07 Continue to enhance list of PCP fax numbers via regular downloads of WebMD information Continue to have front desk ask member & update system with PCP name Continue to auto-fax notes to PCP from transcription when known CRS will continue its existing determination processes for the 10 day approval notice and the 5 day denial notification CRS will continue to enhance its lists of providers and fax numbers in order to ensure that notification for both the 10 day and 5 day denial is sent CRS will continue to send monthly member information to all AHCCCS health plans CRS will explore the development of a reporting mechanism to monitor that consult reports are sent to referring physician w/in 30 days of 1st clinic visit

			NS1 - CRS must improve efforts to meet 45-day timelines for member's referrals to specialty clinic appt. GS 4B – CRS must provide timely written notification to the member's AHCCCS plan when CRS determines its is not a CRS covered benefit.	9/17/07 Accepted. CRS will revise reporting to monitor the 45 day timeline by specialty. Report will be brought to QM/UM Committee on at least a quarterly basis or more frequently as needed to identify material gaps in the network If material gaps identified, strategies will be developed to address CRS staff will continue to work to backfill canceled appointments with outstanding referrals. 9/15/07 Accepted. Notice to cure lifted corrective action already in place. CRS will continue to provide timely, written notification to the member's AHCCCS plan when CRS at St. Joseph's determines that the service requested is not a CRS covered benefit as noted by CRSA "the current policy and new letter templates meet all the requirements".
Corporate Compliance Detect and Prevent Fraud/Abuse			No Deficiencies	
Credentialing	5/22-23/07	11/6-8/08	No Deficiencies	The Joint Commission Accreditation.
Eligibility	5/22-23/07	11/6-8/08	GS 18 - CRS at St. Joseph's must record all required information in the Database, including the AHCCCS ID, Enrolling diagnosis, and Provider/Entity.	8/29/07 Not Accepted. Response due 10/05/07. CRS updated the grievance database to include all required documentation for CYE 2007. CRS will continue to monitor the database to ensure completion of all required fields (AHCCCS ID, if appropriate, enrolling diagnosis & provider/entity).
Financial Reporting	5/22-23/07	11/6-8/08	No Deficiencies	

Grievance/Complaints System	5/22-23/07	11/6-8/08	GS 1 – CRS must provide members with written Notice of Action that meet required format standards.	9/15/07 Accepted with ongoing monitoring. CRS will continue to provide members with written notification and notices of extension that meet required format standards as noted by CRSA that the site has met the "requirements from January through May 2007".
			GS 2 - CRS at St. Joseph's must provide members with written Notices of Action that meet required content standards.	9/15/07 Accepted with ongoing monitoring. CRS will continue to provide a notification that meets content standards as noted by CRSA statement "the current policy and new letter templates meet all requirements".
			GS 3 - CRS at St. Joseph's must provide members with written Notice of Action/Notices of Extension within required timeframes.	9/15/07 Accepted with ongoing monitoring. CRS will continue to provide members with extensions and notices of action as appropriate within the required timeframes as noted by CRSA "the current policy and new letter templates and provider service request meet all requirements".
			GS 4 – CRS must provide the member with a written notice of extension.	9/15/07 Accepted with ongoing monitoring. Notice to cure lifted, corrective action already in place. CRS will continue to provide timely, written notification to the member's AHCCCS plan when CRS at St. Joseph's determines that the service requested is not a CRS covered Benefit as noted by CRSA "the current policy and new letter templates meet all the requirements"
			GS 4A – CRS must provide members with written notices of extension that meet content standards.	9/15/07 Accepted with ongoing monitoring. Notice to cure lifted, corrective action already in place. CRS will continue to provide timely, written notification to the member's AHCCCS plan when CRS at St. Joseph's determines that the service requested is not a CRS covered Benefit as noted by CRSA "the current policy and new letter templates meet all the requirements".

			GS 22 – CRS claim dispute notice of decision must include all required information.	9/15/07 Accepted with ongoing monitoring. CRS will continue to include all required information in the claim dispute notice of decision as evidenced by ongoing monitoring by CRSA which shows that CRS has a process in place to ensure that all claim dispute notices include all required information.
Medical Management Prior Authorization	5/22-23/07	11/6-8/08	MM 6 A - CRS must document in policy its plan for IRR training & testing.	9/17/07 Accepted with ongoing monitoring. CRS will document the processes for inter-rater reliability training, testing & consistency.
Medical Management Concurrent Review	5/22-23/07	11/6-8/08	MM 9 - CRS at St. Joseph's must ensure that concurrent reviews meet required timeline; and document a new review date each time a concurrent review is conducted.	9/17/07 Accepted with ongoing monitoring. CRS continues to improve timeliness of concurrent review process and documentation of review date each time review is conducted. New staff begins August 23, 2007 and will be trained to meet all concurrent review processes and will be monitored for those elements as part of the 90-day performance evaluation.
Medical Management Retro-Review	5/22-23/07	11/6-8/08	MM 6 - CRS at St. Joseph's must document in a policy its plan for inter-rater reliability training and testing, as well as activities to ensure consistency of applying standardized criteria. MM 6A – CRS must conduct regular checks for consistent application of review criteria.	9/17/07 Accepted with ongoing monitoring.. CRS will document the processes for inter-rater reliability training, testing & consistency. 9/17/07 Accepted. CRS will continue to evaluate appropriate staff on an annual basis utilizing the IRR process, in addition to evaluating new staff with in ADHS guidelines CRS will add to the prior auth, in-patient utilization & retrospective review policies the requirement that action will be taken if criteria is not applied in a consistent manner (Attachment D)

				If criteria is applied inconsistently by staff, they will be educated and monitored for improvement by the manager Inconsistent application of criteria will be used in job performance evaluation
Quality of Care Issues	5/22-23/07	11/6-8/08	QM 5 - CRS must implement procedures for identifying QOC issues w/in the care system. QM 6 - CRS must establish a process to monitor the success of interventions implemented to address QOC concerns. MM2 – CRS must document medical utilization management issues regularly, analysis of aggregate data ID of trends & variances, implementation of interventions & reviews of recommendations.	8/29/07 <u>Accepted with ongoing monitoring.</u> A draft QOC policy has been written which delineates the procedure for identifying QOC issues through the grievance, concurrent, retrospective and prior auth processes. 8/29/97 <u>Accepted with ongoing monitoring.</u> CRS will monitor QOC issues, and interventions on at least a quarterly basis in the QM/UM Committee. 9/15/07 <u>Accepted with ongoing monitoring.</u> CRS will improve the documentation of medical management to reflect : Data trends Analysis of untoward trends Action plan for intervention Follow-up to ensure intervention was successful Follow-up of previous meeting recommendations and changes made in response to recommendation

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CCRS – Tucson
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Claims/Encounters	5/8-9/07	September 5-6, 2008	CS4 – CCRS must ensure consistent and timely adjudication of claims within contract requirements.	Tucson Children's Clinics has been out of compliance for the timely adjudication of claims due to the implementation of a new claim system and a system conversion. Tucson Children's Clinic is currently in compliance with 90% of all claims adjudicated within 30 days of receipt and 99% of clean claims within 60 days of receipt. See attached CRS Paid Claims Aging Report. The attached Claim Adjudication Policy was revised to include a 48 hour turnaround time for other departments that must update the claim system if there are issues with eligibility or contracting. Tucson Children's Clinics will use the attached Claims Aging by Recipt Date Report that the Director of Healthcare Support runs daily to monitor claim turnaround time. Currently in compliance **Accepted 8/30/2007.**
			CS5 – CCRS must clearly define within their policy the contract requirements for identifying and recouping erroneously paid claims.	Overpayment/Underpayment & Recoupment Policy revised effective July, 2007. The revised policy outlines the process and procedures for identifying and recouping overpayments. Director of Healthcare Support Reviews the Overpayment/Underpayment Log & Claims Accuracy Report monthly. Effective 10/1/07 we will conduct monthly quality review by auditing 1% of examiner claims. Overpayment/Underpayment Log Monthly Review Claims Accuracy Report monthly. Review Policy Revision with Staff - Aug 5. In compliance. **Accepted 8/30/2007.**
			CS7 – CCRS must clearly define within their policy the contract requirements for identifying and reprocessing erroneously paid claims.	The attached Claims Overpayment/ Underpayment and Recoupment Policy was revised effective July 31, 2007. The revised policy outlines the process and procedure for voiding and reprocessing of an encounter that was previously paid and or recouped. Effective immediately, the Director of Healthcare Support will monitor the Overpayment/Underpayment Log Monthly to ensure procedures outlined in revised policy are followed. Policy

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				revisions were presented to the Staff on August 5, 22007. Due Date = Monthly. In compliance. **Accepted 8/30/2007.**
			CS8 – CCRS must have policy and procedures consistent with contract requirements on reprocessing and paying all overturned claims disputes.	The attached Claim Dispute Policy Revised July 2007 clearly defines the guidelines for reprocessing of overturned claims consistent with the decision within 10 business days. Effective immediately the Director of Healthcare Support will monitor the Provider Claims Dispute Log weekly to validate processing of any overturned claim within 10 days from the date of the decision. Due Date = Weekly. In Compliance. **Accepted 8/30/2007.**
			CS10 – CCRS must implement a comprehensive Claims Training Policy by September 30, 2007.	The attached revised Claims Training Policy, which was revised in July, 2007, was implemented prior to the September 30, 2007 deadline. Other attached supporting documents include: Tucson CRS Project Plan for Developing Claim Training Policy; Training Agenda; Claims Training Checklist; Upcoming Training Schedule; and Claims Processing Training Log. In compliance. **Accepted 8/30/2007.**
			CS12 – CCRS must include all the information, as required in contract, in the Remittance Advice.	Programming was completed on April 30, 2007 to revise our Remittance Advice (attached) to ensure it includes the following requirements: descriptions of all denials, descriptions of all adjustments, the amount billed, the amount paid, and a statement addressing the providers' rights to file a claim dispute. In compliance. **Accepted 8/30/2007.**
			CS13 – CCRS must implement a policy or process to notify CRSA of any cumulative recoupment greater than $50,000 per provider per contract year.	The attached Claims Overpayment/Underpayment and Recoupment Policy, effective July 2007, provides specific guidelines for notifying CRSA of any cumulative recoupment that will exceed $50,000 per provider per contract year. Policy & Procedure requires analysis of the overpayment and determination

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				of recoupment amount prior to action. The attached CRS Over/under Claims Payments Report is forwarded to the Director of Healthcare Support immediately when the cumulative recoupment exceeds the threshold for notification to CRSA. The Policy revisions were presented to the Staff on August 5, 2007. Due Weekly. In compliance. **Accepted 8/30/2007.**
			CS14 – CCRS must implement a policy or process to request approval from CRSA prior to recouping monies from a provider later than 12 months after the date of original payment on a clean claim.	See attached CRS Over/under Payments Report and revised Claims Overpayment/Underpayment and Recoupment Policy, effective July 2007, provides specific guidelines for obtain approval from CRSA prior to recouping from a provider monies later than 12 months after the date of the original payment on a clean claim. Policy & Procedure requires analysis of the overpayment and determination if recoupment from provider is beyond 12 months from the date of the original payment. If overpayment review confirms recoupment is beyond threshold of 12 months the file is forwarded to the Director of Healthcare Support immediately to obtain approval from CRSA prior to action to recoup. The revised Policy was presented to the Staff on August 5, 2007. Due date = Weekly. In compliance. **Accepted 8/30/2007.**
			CS14A – CCRS must implement a process to pay a slow payment penalty on hospital clean claims in accordance with A.R.S. §36-2903.01 (unless otherwise specified in provider subcontract) by September 30, 2007.	Facility claims are being paid timely within 60 days and have not been subject to this penalty. As part of our pre-payable close process, facility claims will be reviewed as to their timeliness of payment. Claims being paid in more than 59 days will be repriced to include a 1% penalty. (See Attachment A - Document Specs for CLM104R01V01). Hospitals will be notified of the potential penalty payment. All Clean claims are currently manually reviewed before payment is issued. The query to automate the facility claim review will be developed by August 10. A report will be developed to identify any clean claims paid outside the 60 days that have not had penalty applied by October 1.

Subcontractor Function	Last Review	Next Review	Identified Deficiencies	Corrective Action Plan Accepted
				Clean claims paid outside 60 days without penalty applied report will be run each payable close check date by the Claims Analyst. **Accepted 8/30/2007.**
			CS15 – CCRS must implement a process and show evidence of receiving and paying at least 25% of all claims electronically (excluding claims processed by PBM).	Tucson Children's Clinics acknowledges the ADHS finding and has developed the attached Project Summary (Attachment CS 15 - A) and Project Plan (Attachment CS 15 - B) to accept inbound electronic claims. Tucson is also committed to reaching the 25% electronic reciept guideline and implement a solution to support electronic payment. This is a significant undertaking requiring coordination with providers, clearinghouses, and Plexis to develop and test. We anticipate completion of the technical components by 12/31/2007 with Plexis development costs of $100,000 and additional costs related to clearinghouse configuration and set-up. Note: Tucson will develop, test, and implement the appropriate mechanisms and processes to support inbound EDI and payment. Full compliance of this measure is dependent on the willingness of providers to submit electronic claims and the completeness and accuracy of data in their submissions. As part of the Project Plan, a report will be developed to identify the volume of claims submitted on paper versus the volume of claims submitted electronically. The percentage of electronic claims will be calculated to determine level of compliance. The report will be executed at least monthly and distributed to the Director of Health Care Support. **Accepted 8/30/2007.**
Coordination of Care	5/8-9/07	September 5-6, 2008	MM10 – CCRS must document the name of PCP on each member record/file; additionally, coordination of care with	When a member is transferred to another regional provider the PCP will receive a copy of the regional transfer form. The Medical Records Manager will audit the Correspondence Log every three

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			members PCP must be documented as well.	(3) months to ensure all PCPs receive a copy of the Regional Transfer Form on their transferred patients **Accepted 8/30/2007.**
			MS4 – CCRS must document the member's decision about whether to develop (execute) an advance directive in the member's medical chart.	To comply with contractual requirements, charts of all members 18 years of age and older were reviewed to ensure that the medical record documented if an Advance Directive (A.D.) was present or not on the member's chart. The charts of new members will be reviewed quarterly and the presence or absence of an A.D. will be recorded on the Patient Summary sheet (Attachment 3). **Accepted 8/30/2007.**
			QM11 – CCRS must ensure that the consultation report is sent to both the referring physician and health plan/program contractor within 30 days of the first clinic visit and is documented in the medical record.	All intake reports (initial clinic visits) are sent to the Clinic's Medical Records Department who sends copies of the visit report to the members' PCP and health plan within thirty (30) days of the visit. Evidence of the mailings are documented in the Correspondence Log, located in the Medical Records Department. The Medical Records manager will audit the Correspondence Log on a monthly basis to ensure compliance. Staff will be educated on an ongoing basis as needed. **Accepted** contingent on receipt of documentation demonstrating Correspondence Log monitoring.
			QM11 – CCRS must ensure that the approval notices to both the referring physician and health/plan program contractor are sent within 10 working days and are documented in the medical record.	A process has been developed whereby the Corporate Compliance Officer will audit every fifth application to ensure that approval notices were sent to the referring physician and health/plan program contractor within 10 working days and the evidence of this mailing is documented in the medical record to ensure at least 85% compliance as required. **Accepted 9/24/2007**
			QM11 – CCRS must ensure eligibility denial notifications are sent to both the referring physician and health	A process has been developed whereby the Corporate Compliance Officer will audit every fifth application to ensure that eligibility denial notices are sent to the referring physician and health/plan

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			plan/program contractor within 5 working days of denial determination and are documented in the medical record.	program contractor within 5 working days of the denial determination and the evidence of this mailing is documented in the medical record to ensure at least 85% compliance as required. **Accepted 9/24/2007**
Corporate Compliance	5/8-9/07	September 5-6, 2008	No deficiencies	N/A
Credentialing	5/8-9/07	September 5-6, 2008	No deficiencies (Joint Commission accredited)	N/A
Eligibility	5/8-9/07	September 5-6, 2008	No deficiencies	N/A
Financial Reporting	5/8-9/07	September 5-6, 2008	FM1 – CCRS must continue its efforts to resolve Plexis implementation issues including creating reporting tools that will satisfy the quarterly financial statement requirements. TPL3 – CCRS must refer cases that involve the above-mentioned circumstances to the authorized representative at CRSA and must not pursue recovery on cases that involve the above-mentioned circumstances unless they are authorized to do so by AHCCCS or by the AHCCCS authorized representative.	Children's Clinics does have a process to ensure its reporting requirements are accurate, timely and complete. The only component missing on the lag tables were extended months of IBNR due to Children's Clinic's need for a Plexis report. That report has been developed and the 3rd Quarter Financial Statements at 3/31/07 did have over 3 months of IBNR listed (See Attachment A - Current Estimate of Remaining Liability (RBUC & IBNR) line). CFO has always reviewed reporting requirements on a quarterly basis to ensure complete and accurate statements and will continue to do so. We will continue our current process **Accepted 8/30/2007.** CCRS will continue to provide members with written Notices of Action and/or Notices of Extension that meet required format standards. We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for format. If there is a problem with the format, the letter is revised before it is sent **Accepted** contingent on receipt of documentation demonstrating compliance and CCRS identifying the individual who will conduct denial log reviews in the absence of Dr. Ghory.
Grievance/Complaints	5/8-9/07	September	GS1 – CCRS must continue to provide	CCRS will continue to provide members with written Notices of

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System		5-6, 2008	members with written Notices of Action and/or Notices of Extension that meet required format standards.	Action that meet required content standards. We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for content. If there is a problem with the content, the letter is revised before it is sent **Accepted** contingent on receipt of documentation demonstrating that any denials are reviewed by the Medical Director, on correct letter templates, and processed in accordance with policy and procedures.
			GS2 – CCRS must provide members with written Notices of Action that meet required content standards.	CCRS will continue to provide members with written Notices of Action that meet required content standards. We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for content. If there is a problem with the content, the letter is revised before it is sent **Accepted** contingent on receipt of documentation demonstrating that any denials are reviewed by the Medical Director, on correct letter templates, and processed in accordance with policy and procedures.
			GS3 – CCRS must provide members with written Notices of Action within the required timeframes.	CCRS will provide members with written Notices of Action within the required timeframes. **Accepted** contingent on receipt of documentation demonstrating compliance. Dr. Ghory and/or Sandy Arvizu, R.N. will review a "pend" report of all requests for services as well as the denial log twice/week to make sure that members receive written Notices of Action within the required timeframes. Expedited requests will be reviewed daily. When Dr. Ghory is not available, Sandy Arvizu will review above

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				with Linda Aguirre, R.N. **Additional response due 10/15/07.**
			GS4 – CCRS must provide the member with a written Notice of Extension when taking more than 14 (standard) or 3 (expedited) working days to decide initial request for service authorization, or when it determines that the service requested is not a CRS covered benefit, and refer the request to the member's primary AHCCCS plan.	CCRS will provide the member with a written Notice of Extension when taking more than 14 (standard) or 3 (expedited) working days to decide initial request for service authorization, or when CCRS determines that the service requested is not a CRS covered benefit, and refers the request to the member's primary AHCCCS plan **Accepted** contingent on receipt of documentation demonstrating compliance. We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the Notice of Extension to be sure that the timelines are met. If there is a problem, it is addressed immediately **Additional response due 10/15/07**.
			GS4a – CCRS must provide members with written Notices of Extension that meet required content standards.	CCRS will provide timely, written notification to the member's primary AHCCCS plan when CCRS determines that the service requested is not a CRS covered benefit **Accepted** contingent on receipt of documentation demonstrating compliance. We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the letter to the member's primary AHCCCS plan to be sure that the required timelines are met. If there is a problem, it is addressed immediately. **Additional response due 10/15/07**.
			GS4b – CCRS must provide timely, written notification to the member's primary AHCCCS plan when it determines that the service requested is not a CRS covered benefit.	CCRS will provide timely, written notification to the member's primary AHCCCS plan when CCRS determines that the service requested is not a CRS covered benefit **Accepted** contingent on receipt of documentation demonstrating compliance.

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				We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the letter to the member's primary AHCCCS plan to be sure that the required timelines are met. If there is a problem, it is addressed immediately **Additional response due 10/15/07**
			GS6 – CCRS must maintain and implement a grievance process which documents, monitors, intervenes, and reports Non-QOC grievance occurrences.	Children's Clinics has revised it's (sic) Grievance Policy (attached) to comply with these requirements (see "Procedures; 5. Basic resolution process; "m"). All QOC and Non-QOC issues will be entered in the grievance log and reported to ADHS/CRSA monthly which will include intervention strategies. Summary of grievance log and process is reported to UM/QM Committee quarterly. Trends will be noted and action taken if necessary. **Accepted 8/30/2007.**
			GS6 – CCRS' Grievance Policy must contain a provision that the member may file a grievance with CRSA or the CRS regional contractor in the Grievance Policy.	Children's Clinics has revised it's Grievance Policy to comply. (Procedures ; 3. Filing; "b"). Members to be informed of Grievance Policy in Intake Packet, and Patient Rights posted on the website and through out the clinic. UM/QM Committee to review Grievance Policy annually or as needed. Substantial revisions will be communicated to appropriate individuals. **Accepted 8/30/2007.**
			GS6 – CCRS must define "grievance" in its Grievance Policy as a CRS member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.	Children's Clinics has revised it's Grievance Policy to comply. (Policy; second paragraph). **Accepted 8/30/2007.**
			GS21 – CCRS must comply with claims dispute requirements related to timely written acknowledgment and decisions.	Tucson Children's Clinics developed an acknowledgement letter (an example is included in the Claim Dispute Policy as attachment B) that was approved by CRSA. See Exhibit B for GS21. Acknowledgement letters have been in production since June,

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				2007. Due date = weekly. In compliance. **Accepted 8/30/2007.**
			GS22 – CCRS claim dispute notices of decision must include all required information.	The attached Claim Dispute Policy was revised April 2007. It clearly defines required information. Director of Healthcare Support reviews required information weekly during Claims Review. Currently in compliance. **Accepted 8/30/2007.**
			GS23 – CCRS must have a process of consistently recording and maintaining records of claims disputes.	The attached Claims Dispute Policy was revised April 2007. It clearly defines the guidelines for recording and maintaining claim disputes. Claim disputes are recorded on the claim dispute log as soon as they are received. Paper records are filed in the Claims Department. Both the provider dispute log and the paper files are faxed to CRSA monthly. Director of Healthcare Support reviews disputes weekly during Claims Review. In compliance. **Additional response due 10/15/07**.
			GS24 – CCRS must maintain evidence in the claims dispute case record that denied claims reversed in the claims dispute process are paid within 10 business days of the date the denial is reversed.	The attached revised CRS Claims Overpayment/Underpayment and Recoupment Policy effective July 2007 provides specific guidelines for notifying CRSA of any cumulative recoupment that will exceed $50,000 per provider per contract year. Policy & Procedure requires analysis of the overpayment and determination of recoupment amount prior to action. The attached CRS Over/ Underpayments file is forwarded to the Director of Healthcare Support immediately when the cumulative recoupment exceeds the threshold for notification to CRSA. Due date = weekly. In compliance 11/01/2007. **Additional response due 10/15/07**.
Medical Management – Prior Authorization	5/8-9/07	September 5-6, 2008	MM6 – CCRS must require that their Prior Authorization Review Specialist be an Arizona-licensed registered nurse, physician or physician's assistant.	Our RN Utilization Coordinator is a Arizona-licensed registered nurse. See attached Prior Authorization Policy. Concurrent and Retrospective Review is performed by Mary Jo Ghory, MD, Medical Director for Utilization Management; Sandy Arvizu, R.N., Utilization

Subcontractor Function	Last Review	Next Review	Identified Deficiencies	Corrective Action Plan Accepted
				Coordinator; and Linda Aquirre, R.N., Eligibility/Prior Authorization Specialist. The attached Organization Chart reflects these titles and credentials. **Accepted 9/28/2007.**
			MM6 – CCRS must arrange inter-rater reliability (IRR) training and testing for all staff involved in determining medical necessity, including the Medical Director	IRR training and testing occurs for all staff involved in Prior Authorization, Concurrent Review and Retrospective Review during the Case Review Committee, at least annually, and as needed, if there are issues and/or if there is a change of staff. (See IRR Policy, attached.) The Case Review Committee will monitor this process and this will be reflected in the minutes of that committee **Accepted** contingent upon CCRS identifying membership on the case review committee. Additionally, all 3 medical directors must participate in IRR testing and training.
Medical Management – Concurrent Review	5/8-9/07	September 5-6, 2008	MM6 – CCRS must arrange inter-rater reliability (IRR) training and testing for all staff involved in determining medical necessity, including the Medical Director	IRR training and testing occurs for all staff involved in Prior Authorization, Concurrent Review and Retrospective Review during the Case Review Committee, at least annually, and as needed, if there are issues and/or if there is a change of staff. (See IRR Policy, attached.) The Case Review Committee will monitor this process and this will be reflected in the minutes of that committee **Accepted** contingent upon CCRS identifying membership on the case review committee. Additionally, all 3 medical directors must participate in IRR testing and training.
Medical Management – Retro Review	5/8-9/07	September 5-6, 2008	MM6 – CCRS must arrange inter-rater reliability (IRR) training and testing for all staff involved in determining medical necessity, including the Medical Director	IRR training and testing occurs for all staff involved in Prior Authorization, Concurrent Review and Retrospective Review during the Case Review Committee, at least annually, and as needed, if there are issues and/or if there is a change of staff. (See IRR Policy, attached.) The Case Review Committee will monitor this process and this will be reflected in the minutes of that committee **Accepted** contingent upon CCRS identifying membership on the case review committee. Additionally, all 3 medical directors must participate in IRR testing and training.

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Quality of Care Issues	5/8-9/07	September 5-6, 2008	QM4 – CCRS must establish a policy/process for monitoring its delegated entities on an ongoing basis and review them formally at least annually.	Our existing two policies entitled "Monitoring of Delegated Entities" and ""Utilization Management/Quality Management (QM/UM Committee)" (**revised versions attached**) were enhanced to include the month of the annual delegated contract review by the UM/QM Committee as well as corrective active verbiage, monitoring and reporting of incidents relating to delegated entities as required, and documentation of these activities in the UM/QM Committee minutes. The Committee will also review and implement corrective action plans relating to delegated entities as needed. **Accepted 9/24/2007**
			QM4 – CCRS must have a contract for all functions or responsibilities delegated to other entities.	Utilizing our list of delegated services, we verified that we have contracts with for all delegated services with the exception of LabCorp. We have been communicating with LabCorp the need for a formal contract. We have sent them a contract to sign to ensure compliance with this requirement. We monitor the list on ongoing basis to ensure signed contracts are on file for all delegated services LabCorp has agreed to sign a contract that is currently with their attorneys for review. However, if the contract is not signed by 10/1/07, we will notify LabCorp of our intent to terminate our relationship with them and will begin the transition to Sonora Quest. We have already had discussions with Sonora Quest and they would be prepared to execute a contract and begin services with a one month notice. We have a long-term relationship with LabCorp and are very hopeful that this contract can be executed by 10/1/07 allowing us to continue this partnership. **9/24/07 Accepted** contingent upon the receipt of a signed lab contract.
			QM4 – CCRS must ensure that the subcontractor implements corrective	Potential quality issues are identified by ongoing review of input from providers, patients, and employees regarding services to Clinic

Subcontractor Function	Last Review	Next Review	Identified Deficiencies	Corrective Action Plan Accepted
			action if any deficiencies are identified.	patients performed by delegated entities. Examples of processes monitored on an ongoing basis to capture complaints and/or concerns include: 1) The grievance log to identify complaints/ concerns; 2) Performance measures identified in the contact with the entity to ensure compliance with standards; and patient surveys. Potential quality concerns are reported to, and addressed, by the UM/QM Committee Our existing policy entitled "Monitoring of Delegated Entities" (**revised version attached**) was enhanced to include that the QOC database is used to track and trend QOC concerns related to contract providers. **Accepted 9/24/2007**
			QM5 – CCRS must have a process for monitoring quality of care that includes reporting quality of care concerns from anywhere in the CCRS managed care system (e.g. providers, delegated services, acute hospitalizations, UM/case management review).	All grievances and complaints are routed to the Grievance Coordinator to be logged in the Grievance data base. This includes both QOC and Non-QOC concerns. The Grievance Coordinator distributes the grievance/complaint to the manager/ director most closely associated with the subject of the grievance. If the subject of the grievance is a Medical provider, the issue is referred to the Medical Director. If the grievance affects more then one department or entity, all related managers/ directors are given the grievance/ complaint for investigation and resolution. For example, if a complaint alleges that the wait at the pharmacy is too long, the following individuals will be responsible for handling the situation: the COO (who manages the Wal-Mart contract); the Corporate Compliance Officer (who manages quality issues pertaining to delegated services/contracts); and the Utilization Manager (who investigates resource allocation and use). Utilization issues are discussed with the Utilization Manager or designee whenever there is a possible utilization issue involved in the grievance or complaint. Likewise, the Corporate Compliance Officer is notified if the grievance /complaint involves a delegated service/contract. The Grievance Coordinator will guide the process, compile and report

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				findings to ADHS and the UM/QM Committee for internal tracking, discussion, and trending. This will include summary information derived from Utilization and/or Compliance findings. **9/24/07 Accepted** contingent upon the revision to Policy UM.010 to include as an UM activity referrals to the QM Department of any actual/potential QOC concerns to QM Department for further investigation.

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Claims/Encounters	4/24-5/07	10/16-17/08	CS 4, CS 15 - CRS Yuma must ensure consistent and timely payments are met according to contract requirements.	8/15/07 Accepted. The Yuma CRS (YCRS) Business Operations Supervisor will run claim reports to identify open claims and analyze the reason for non-payment. Information will be reviewed with claims staff and a plan will be discussed to ensure 90% of claims are paid within 30 days and 99% within 60 days. A monthly report will be run on paid claims to determine if the timeframe were met. The issues identified will be tracked and trended and reviewed with staff. YCRS is currently receiving UB claims from Yuma Regional Medical Center (YRMC) electronically. YCRS continues to work with YRMC on ensuring the data is received accurately and on a timely basis. YRMC Accounting Department provided a copy of the YCRS Claims Processing and payment policy to ensure process is acceptable.
Coordination of Care	4/24-5/07	10/16-17/08	NS 1 - CRS Yuma must ensure that a clinic cancellation by providers does not affect the regularly scheduled clinic for that specialty. CRS Yuma must revise their Provider Manual and require adequate time for clinic cancellations from providers.	8/15/07 Accepted with ongoing monitoring CRS Yuma will: Update the CRS Yuma provider manual with a requirement that the clinic provider provide CRS Yuma at least 30 days advance notice of a clinic cancellation and provide an alternate date to

				reschedule the clinic. Review and analyze the monthly Provider No Show report to track the providers that are canceling clinics and the reasons why. Providers that show a cancellation trend will be referred to the CRS Yuma Medical Director to determine what actions are needed to decrease the clinic cancellations.
			QM 11 - CRS Yuma must ensure eligibility denial notifications are sent to the referring physician and health plan within 5 working days of denial determination.	9/13/07 <u>Accepted with ongoing monitoring.</u> CRS Yuma is currently conducting a FMECA assessment on all aspects of the medical eligibility process. CRS Yuma will change their current process to include the following: Member Application Another CRS staff member will be cross-trained in the CRS Eligibility process to ensure applications received are routed and completed within timelines Nursing and Social Services will complete their assessments on the day of the intake interview, so during the members Enrollment Clinic all that needs to be completed is the Medical Directors assessment and authorization of approval or denial <u>Medical Eligibility denials</u> 1. A denial blank template letter will be attached to the new enrollment chart. 2. Have the Medical Director sign all medical eligibility letters before the end of the applicants enrollment clinic 3. Nursing will provide the letters to the front office staff no later than the next business day after the applicants Enrollment Clinic 4. Front Office staff will mail the denial letter the day it is received from nursing to the appropriate

				stakeholders. 5. If Nursing has other post-clinic activities they can complete them without affecting the mailing of the denial letter. 8/28/07 – Practice Coordinator or designee will compare a new Application Checklist that has been sent in attachment and completed for each new application against a Rehab Manager Weekly Application Report to ensure all denials are sent within five working days of denial determination.
Corporate Compliance Detect and Prevent Fraud/Abuse		10/16-17/08	GA 5 - CRS Yuma or YRMC must conduct audits or reviews that would be adequate to detect fraud and program abuse within the CRS Yuma Clinic or any of the Clinic's contractors. CRS Yuma must ensure that their designated Corporate Compliance Officer attends and participates in the Yuma RMC Corporate Compliance Committee meetings.	8/15/07 Accepted. The Yuma CRS Compliance and Regulatory Specialist began attending the Yuma Regional Medical Center Corporate Compliance Committee Meetings in May of 2007. Pam Miller, Director of Community Patient Services who is the Administrative Director for Yuma CRS, will attend the meetings as the designated CRS compliance representative and work in conjunction with the hospital's Corporate Compliance Officer, Pam Nalley, to identify and conduct an annual audit review to detect potential fraud and program abuse within the Yuma CRS clinic.
Credentialing	4/24-5/07	10/16-17/08	No Deficiencies	The Joint Commission Accreditation.
Eligibility	4/24-5/07	10/16-17/08	No Deficiencies	
Financial Reporting	4/24-5/07	10/16-17/08	FM 1 - CRS Yuma must provide complete, timely and accurate financial records.	8/15/07 Accepted. Luz Valle, CRS Business Supervisor, met with Cynthia Lane and Vicki Margaritis on July 09, 2007 for assistance on creating a Correction Action Plan for the ADHS Financial Report.

				Luz Valle and Todd Hirte, Managed Care Director met on July 18, 2007 and created a checklist of those areas identified as discrepancies in previous letters sent to Yuma CRS by ADHS. Checklist will be implemented in the Yuma CRS ADHS Financial Report quarter ending 06/30/07.
Grievance/Complaints System	4/24-5/07	10/16-17/08	GS 1 - CRS Yuma must provide Notices of Action and/or Notices of Extension Template Letters, in English or Spanish as appropriate.	8/15/07 Accepted. CRS Yuma has developed a Spanish Template letter for Notice of Action and Notices of Extension. The MM/UM Executive Committee will perform monthly trending of the Notice of Action or Notice of Extension letters and perform reviews based on the preferred language (English or Spanish only) to determine if the appropriate template was used for communicating with the member.
Medical Management Concurrent Review	4/24-5/07	10/16-17/08	MM 9 - CRS Yuma must develop a written plan to implement corrective action when established timelines are not met.	8/13/07 Accepted. CRS Yuma will perform training and re-education with staff members not meeting timelines affecting concurrent reviews. Additional training provided by CRSA will be implemented as needed by CRS Staff. A CRS insurance report is being generated and it will capture all hospitalizations and emergency room visits. The report will be provided daily to the nursing staff for all concurrent review processes. Concurrent review will be performed 24 hours or 1 business day after notification of admission and every 2 days after. Review will be performed 28 days from date of notification.
Medical Management Prior Authorization	4/24-5/07	10/16-17/08	MM 6, MM 6A - CRS Yuma must arrange IRR training and testing for all staff involved in medical necessity determination, including	8/15/07 Accepted IRR Training: June 6, 2007 and June 25 2007 Training and Inter-

			the Medical Director. CRS Yuma must conduct regular checks for consistent application of review criterion for IRR and document the findings. CRS Yuma must arrange structured IRR training and testing for all staff involved in medical necessity determination, including the Medical Director on annual basis. CRS Yuma must conduct regular checks for consistent application of review criterion for IRR and document the findings. CRS Yuma must develop a written plan to implement corrective action when established timelines are not met.	rater reliability testing was performed for the nurse review staff. Based on requirements of CRSA; the frequency that Yuma CRS will perform inter-rater reliability is based on the experience level of the UM staff. Each reviewer must be at a performance rating of 80%. The criteria are as follows: 1. Experienced New Hire: Within 6 months of hire 2. New Hire without experience: Within 3 months of hire and at 6 months 3. New Hire without experience at one year of service: Twice Annually 4. Experienced Nurse who has a long history with the CRS Program and are familiar with the guidelines: Twice Annually 5. Staff who show evidence of meeting 80% or higher inter-rater reliability testing: Annually The Medical Director will have inter-rater reliability performed annually within the fiscal year as outlined in the Medical Directors contract. The staff performed at the 80% performance measure for prior-authorization and concurrent review. The staff did not meet the performance measure for retrospective review (emergency admission), therefore, the staff will have re-training and inter-rater reliability performance testing at 3 months.
Medical Management Retro-Review	4/24-5/07	10/16-17/08	MM 6, MM 6A - CRS Yuma must arrange IRR training and testing for all staff involved in medical necessity determination, including the Medical Director. CRS Yuma must conduct regular checks for consistent application of review criterion for IRR and document the findings.	8/15/07 Accepted with ongoing monitoring. IRR Training: June 6, 2007 and June 25 2007 Training and Inter-rater reliability testing was performed for the nurse review staff. Based on requirements of CRSA; the frequency that Yuma CRS will perform inter-rater reliability is based on the experience level of the UM staff. Each reviewer must be at a performance rating

			CRS Yuma must arrange structured IRR training and testing for all staff involved in medical necessity determination, including the Medical Director on annual basis. CRS Yuma must conduct regular checks for consistent application of review criterion for IRR and document the findings. CRS Yuma must develop a written plan to implement corrective action when established timelines are not met.	of 80%. The criteria are as follows: 1. Experienced New Hire: Within 6 months of hire 2. New Hire without experience: Within 3 months of hire and at 6 months 3. New Hire without experience at one year of service: Twice Annually 4. Experienced Nurse who has a long history with the CRS Program and are familiar with the guidelines: Twice Annually 5. Staff who show evidence of meeting 80% or higher inter-rater reliability testing: Annually The Medical Director will have inter-rater reliability performed annually within the fiscal year as outlined in the Medical Directors contract. The staff performed at the 80% performance measure for prior-authorization and concurrent review. The staff did not meet the performance measure for retrospective review (emergency admission), therefore, the staff will have re-training and inter-rater reliability performance testing at 3 months. Please see attached Inter-rater reliability documents. Yuma CRS developed a policy for Inter-rater reliability which outlines corrective actions for when the staffs do not meet required performance measure of 80%. Policy attached for review and approval.
Quality of Care Issues	4/24-5/07	10/16-17/08	QM 6 - CRS Yuma must send acknowledgement and closure letters to members or their guardians who express a potential quality of care concern. CRS Yuma must list the "provider/entity" for each QOC and non-QOC case. CRS Yuma must ensure eligibility denial	9/12/07 <u>Accepted with ongoing monitoring.</u> CRS Yuma will send acknowledgement and closure letters to members or their guardians who express a potential quality of care concern. CRS Yuma will thoroughly complete all database

			notifications are sent to the referring physician and health plan within 5 working days of denial determination.	entries required by CRSA for each QOC and Non-QOC case. CRS Yuma will follow guidelines set forth in the Grievance policy and procedure approved by CRSA.